STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065176	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Rehabilitation & Care Center	500 Geneva St Aurora, CO 80010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure notification to the resident representative of a significant change in the resident's physical, mental or psychosocial status for one (#11) of three residents reviewed for change of condition out of 20 sample residents.Specifically, the facility failed to notify Resident #11's representative of the resident's deteriorating wounds in a timely manner.Findings include:I. Facility policy and procedureThe Notification of Change policy, revised January 2025, was provided by the nursing home administrator (NHA) on 7/28/25 at 12:11 p.m. The policy read in pertinent part, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family members or legal representative when there is a change requiring such notification. Circumstances requiring notification include significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include life threatening conditions or clinical complications. II. Resident #11A. Resident statusResident #11, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included cellulitis of the right lower limb, pleural effusion (a buildup of fluid in the tissue that lines the lungs), immunodeficiency (immune system unable to defend the body from foreign or abnormal cells), cirrhosis of liver (chronic liver damage), chronic venous hypertension with ulcer and inflammation of both lower extremities (high pressure within leg veins which causes fragile skin prone to opening).The 6/26/25 minimum data set (MDS) assessment revealed Resident #11 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required set up assistance with eating and repositioning and substantial assistance with dressing, transferring to the shower, toileting and personal hygiene.B. Resident representative interviewResident #11's representative was interviewed on 7/21/25 at 2:00 p,m. The representative said the facility did not contact her for most of Resident #11's condition changes and she often found things out later. The representative said she was not notified of any changes with the resident during the previous two weeks prior to Resident #11's hospitalization on 7/12/25. She said she last met with the facility on 6/20/25, at which time she understood Resident #11 required a few more weeks of physical therapy and then he would potentially be discharged to home with assistance. The representative said she was notified on 7/12/25, the date of Resident #11's transfer to the hospital, that his vital signs and level of consciousness had changed and he was lethargic. The representative said she was surprised to learn from the hospital physician that Resident #11's wounds had worsened and he had an infection because nothing was communicated to her from the facility about his wounds worsening. C. Record ReviewThe impaired skin integrity care plan, initiated 6/1/25, revealed Resident #11 had skin ulcers on both legs, including the right achilles (heel) and required wound care and measurements of the wounds width, length, depth, type of tissue and exudate and any other notable changes or observations.The wound care physician (WCP) note, documented on 7/9/25 at 9:42 p.m., revealed the following changes of Resident #11's wounds:On 7/9/25, Resident #11's right achilles wound measured 13.6 centimeters (cm) width by 6.4 cm length by 0.3 cm depth. This was an increase from 7/2/25, when it measured 6.2 cm by 6.3 cm by 0.3 cm. The WCP documented the wound had worsened.On 7/9/25, Resident #11's right lateral foot wound measured 10.0 cm by 5.6 cm by 0.1 cm. This was an increase from 7/2/25, when it measured 6.6 cm by 4.0 cm by 0 cm. The WCP documented the wound had worsened.The WCP documented the care plan was discussed with Resident #11 and the nursing staff. It documented an ultrasound on 7/3/25 revealed mild to moderate peripheral artery disease (PAD) was suspected in the resident's legs with occlusion of the right dorsalis pedis (a blockage in the artery on top of the foot). A nursing progress note, dated 7/9/25 at 7:43 p.m., documented the PCP (primary care physician) and the WCP reviewed Resident #11's ultrasound result and recommended a vascular consult. The note documented a message had been left at an office for this consult.An interdisciplinary team (IDT) note, written by the director of nursing (DON) on 7/11/25 at 9:45 a.m., documented the worsening of Resident #11's wounds and Resident #11 had been noncompliant with lab draws and incontinence care.A PCP progress note, dated 7/11/25 at 5:32 p.m., documented Resident #11's wound worsening was unavoidable due to poor oral intake, the resident's refusals for supplementation and his immunocompromised status. A nursing progress note, dated 7/12 at 2:40 p.m., documented Resident #11's change of condition. It documented Resident #11 was confused and his blood pressure was 82/49 millimeters of mercury (mmHg), his heart rate was 115 beats per minute (bpm) and his oxygen saturation (level of oxygen in the blood) was 86% (percent) with an oxygen

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#6) of seven residents reviewed for abuse out of 20 sample residents were free from abuse.Specifically, the facility failed to protect Resident #6 from abuse by Resident #9.Findings include:I. Facility policy and procedureThe Abuse, Neglect and Exploitation policy, reviewed January 2025, was provided by the nursing home administrator (NHA) on 6/30/25 at 12:00 p.m. It read in pertinent part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The facility will have written procedures to assist staff in identifying the different types of abuse: mental/verbal abuse, sexual abuse, physical abuse and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident-to resident altercations. Possible indicators of abuse include but are not limited to: resident-to-resident, staff or family report of abuse, verbal abuse of a resident overheard, and physical abuse of a resident observed.II. Physical abuse of Resident #6 by Resident #9 on 6/9/25A. Facility investigationThe facility investigation of the incident involving Resident #6 and Resident #9 was provided by the NHA on 7/23/25 at 9:54 a.m. The investigation documented that on 6/9/25 at 2:30 p.m. it was reported Resident #9 approached Resident #6 and Resident #6's representative and called Resident #6 an explicit word. Resident #9 then proceeded to make contact with Resident #6's arm.The immediate intervention was to take Resident #9 to the dining room by therapy staff and Resident #6 was assessed with no noted changes.Licensed practical nurse (LPN) #2 documented in her statement that Resident #6 and his representative were sitting in the hallway. Resident #9 approached them and Resident #9 called Resident #6 an explicit word and proceeded to hit Resident #6 in the arm. The investigation documented Resident #6's representative was interviewed by the facility over the phone and the representative said she was sitting with Resident #6 when Resident #9 approached her and asked her if she knew what an (explicit word) was. Resident #6's representative said Resident #9 pointed at Resident #6 and made a nudge contact with his arm and said this guy is the biggest (explicit word) here. Therapy staff came and redirected Resident #9.A 6/9/25 statement from the director of nursing (DON) documented that at approximately 2:45 p.m. a nurse notified the DON that Resident #9 went to Resident #6 and called him an explicit word and hit him on his right arm. Resident #9 was immediately redirected by staff.B. Resident #9 (assailant)1. Resident statusResident #9, age greater than 65, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included severe vascular dementia with behavior disturbance, type 2 diabetes mellitus, post traumatic stress disorder (PTSD) and major depressive disorder.The 6/24/25 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of seven out of 15. He needed substantial assistance with bathing, supervision with transfers and set up assistance for other activities of daily living (ADL). The assessment did not document the resident had physical or verbal behaviors toward others.2. Record reviewResident #9's dementia care plan, revised 7/23/25 documented the resident had a history of anger outbursts, delusional thinking, PTSD and wandering related to a diagnosis of dementia with psychotic behaviors. On 4/6/25 Resident #9 had a behavior outburst during coffee social and threw coffee on another resident. On 6/9/25 Resident #9 was observed engaging in physical contact and using inappropriate language toward another resident.Pertinent interventions, revised 6/14/25 included one-to-one activity tailored to the resident's preferences, anticipating and meeting the resident's needs, intervene as necessary to protect the rights and safety of others, approaching the resident and speaking in a calm manner, removing the resident from the situation and taking him to an alternate location as needed.A 6/9/25 nursing note documented that at approximately 2:30 p.m., the nurse was approached by an occupational therapist (OT). According to the OT, a resident-to-resident physical contact occurred in the hallway. The nurse immediately went to investigate. Staff quickly separated Resident #9 from Resident #6. Resident #6's representative, who was visiting, stated that Resident #9 went up to them, called Resident #6 an explicit word, then hit Resident #6 on his right arm. No bruise, redness or abrasion was observed on the resident's right arm and the resident's skin remained intact. Resident #6 and his representative also stated that Resident #6 did not hit Resident #9. The NHA and the physician were notified.A 6/9/25 alert note documented the facility contacted the local police department to report a resident-to-resident physical altercation. A 6/10/25 social services note documented Resident #9

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure supervision and monitor assistive devices to prevent accidents for one (#1) of three residents reviewed for accidents out of 20 sample residents. Resident #1 was admitted to the facility for skilled nursing care on 6/13/25 .The resident's care plan directed staff to utilize a mechanical lift for transfers. On 6/18/25, Resident #1 was noted to have pain to her left upper extremity and bilateral lower extremities after being lowered to the floor with the use of a mechanical lift by certified nurse aide (CNA) #1. After the resident's fall, CNA #1 and CNA #6 proceeded to assist Resident #1 into her wheelchair using the mechanical lift, prior to the resident being assessed by a registered nurse (RN) (see staff interviews below). Resident #1 was transported to the hospital on 6/18/25 where it was revealed that the resident had sustained fractures to her upper left arm (humerus) and both legs (tibia). The facility investigation after the incident revealed CNA #1 attempted to transfer Resident #1 using the mechanical lift and did not have additional staff members present to assist withthe transfer. Specifically, the facility failed to:-Ensure staff transferred Resident #1 appropriately with a mechanical lift which resulted in a fall with major injury for the residents; and,-Ensure staff did not move Resident #1 after a fall prior to being assessed by a RN.Findings include:I. Facility policy and procedureThe Safe Resident Handling/Transfers policy, revised 6/18/25, was provided by the nursing home administrator (NHA) on 7/28/25 at 12:11 p.m. It read in pertinent part, All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. Two staff members must be utilized when transferring residents with a mechanical lift. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur. The staff must demonstrate competency in the use of mechanical lifts prior to use and annually with documentation of that competency placed in their education file.II. Resident #1A. Resident statusResident #1, age [AGE], was admitted on [DATE]. According to the June 2025 computerized physician orders (CPO), diagnoses included end stage renal (kidney) disease requiring dialysis, COPD (chronic obstructive pulmonary disease, a lung disease), diabetes, respiratory failure, heart failure, left below the knee and right above the knee amputations.The 6/18/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #1 required set up assistance with eating and was dependent on staff for toileting, showering, dressing and transfers, including lying to sitting and bed to chair.B. Incident investigationThe facility investigation for Resident #1's fall incident on 6/18/25 was provided by the NHA on 6/30/25 at approximately 3:00 p.m.The investigation documented that on 6/18/25 at 3:45 a.m. Resident #1 sustained a fall while being transferred from her bed to go to dialysis. It documented Resident #1 was sent to the hospital for her pain and the hospital found Resident #1's injuries included a fracture of the left arm and both legs.The investigation documented Resident #1 was interviewed on 6/18/25 via telephone and stated that CNA #1 gave her a bed bath and got her dressed for dialysis. The investigation documented CNA #1 attempted to transfer the resident from the bed to her wheelchair with a mechanical lift when Resident #1 slipped and landed on the floor. It documented the nurse (RN #s) assessed Resident #1 and got her back to bed. It documented the resident had pain in her knees and requested to be transferred to the hospital.The investigation included a statement documented by RN #3 on 6/18/25. It documented CNA #1 said Resident #1 was assisted down (to the floor) during the mechanical lift transfer. It documented RN #3 arrived to the resident's room and found Resident #1 sitting in a wheelchair and the resident complained of pain to her upper left extremity. The statement documented Resident #1 said that she fell on her arm. It documented Resident #1 later complained of pain to her bilateral lower extremities and the physician ordered pain medication and x-rays.The investigation included a statement documented by CNA #1 on 6/18/25. It documented CNA #1 transferred the resident using a mechanical lift sling the resident had requested, the sling broke, and CNA #1 attempted to stop her from falling and the resident had left arm pain after the incident.-The statement revealed CNA #1 transferred the resident using the mechanical lift without other staff members present.The investigation included a phone interview with CNA #6 documented on 6/18/25. It documented CNA #1 had been instructed to call for assistance with transferring the resident when Resident #1's hygiene care was completed. It documented CNA #1 called CNA #6 to assist with the resident's transfer and when CNA #6 arrived to the room, Resident #1 was on the floor. It documented CNA #1 told CNA #6 that she attempted transferring the resident by